ASPIRE DASHBOARD

SAFETY

The Institute of Medicine (IOM) considers safety to be one of the six domains of healthcare quality. The IOM defines safety as avoiding injuries to patients from care that is intended to help them.

Methicillin-resistant Staphylococcus Aureus (MRSA) Infection Rate

Number of Methicillin-resistant Staphylococcus Aureus (MRSA) infections per 1,000 bed days of care.

Ventilator-Associated Pneumonia (VAP) Rate

Number of ventilator-associated pneumonias (VAP) per 1,000 ventilator days.

Central Line Associated Blood (CLAB) Stream Infections Rate

Number of central line associated blood (CLAB) stream infections per 1000 central line days. A central line is an intravascular catheter that terminates at or close to the heart or in one of the great vessels which is used for infusion, withdrawal of blood, or hemodynamic monitoring.

Composite Surgical Care Improvement Project (SCIP)

This measure consists of several measures that assess the care of Veterans who have had surgery. The individual measures include the percent of surgery patients: (1) who received treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery; (2) whose doctors ordered treatments to prevent blood clots after certain types of surgeries; (3) who were given the right kind of antibiotic to help prevent infection; (4) whose preventive antibiotics were stopped at the right time (within 24 hours after surgery); (5) heart surgery patients whose blood sugar (blood glucose) is kept under control in the days right after surgery; (6) who had hair removed (if necessary) using a safe method like electric clippers or hair removal cream rather than a razor; (7) who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection; and (8) who were taking heart drugs called beta blockers (drugs used routinely after a heart attack) before coming to the hospital and were kept on the beta blockers during the period just before and after their surgery; (9) who had patients with peri-operative temperature management (this refers to Surgery patients for whom either active warming was used intraoperatively for the purpose of maintaining normothermia or who had at

least one body temperature equal to or greater than 96.8° Fahrenheit/36° Celsius recorded within the 30 minutes immediately prior to or the 15 minutes immediately after Anesthesia End Time); (10) who had their urinary catheter removed on PostOp day 1 or PostOp day 2 (day of surgery being day 0).

Hospital Acquired Pressure Ulcers

Hospital Acquired Pressure Ulcers (HAPU) are staged according to the severity of the skin breakdown that has occurred. The staging ranges from Stage I (least severe) to Stage IV (most severe). The ASPIRE report includes the hospital acquired pressure ulcers that are Stage II or greater. Stage II pressure ulcers are when skin breaks open, wears away, or forms an ulcer, which may be tender and painful.

Even with appropriate nursing care, some pressure ulcers are unavoidable due to patient-specific factors; therefore, some facilities with larger populations of very elderly and/or debilitated patients may have higher HAPU rates.

In addition, capture of hospital-acquired pressure ulcer data is dependent on consistent use of a specific documentation tool within all VHA facilities. Consistent use of the tool may therefore cause some facilities to appear to have higher rates than facilities not using the tool, since data cannot be captured. **Current electronic data reporting does not allow for correction of inaccurately captured clinical documentation.**

The numbers shown in the VA ASPIRE report represent the **RATE** of hospital acquired pressure ulcers at a particular facility. The report includes medical and surgical patients – it does not include patients in an ICU, Community Living Center or in psychiatry. The rate is calculated based upon the number of discharged patients who were originally admitted to a medical or surgical ward and who developed a Hospital Acquired Pressure Ulcer (HAPU) stage II or greater per 1000 hospital days. (Patients are limited to those who have a length of stay 48 hours or longer. Hospital days are the sum of the length of stay for those discharged patients who were admitted to medical surgical units)

Many Hospital Acquired Pressure Ulcer reports use **prevalence** data. This is the number of patients who have a HAPU on any given day divided by all patients in relevant units on that day. It is typically a one day snapshot collected periodically, e.g. monthly, quarterly or annually.   Prevalence data should not be compared to the rate data presented in this report. They are two different methods of calculating and not equivalent.

The calculations in the ASPIRE report are based upon the following information:

Indicator Statement: The rate of patients who develop hospital-acquierd perssure ulcers Stage II or greater.

Population: The report includes discharged patients who were initially admitted to medical or surgical units

Calculation: The numbers shown in the VA ASPIRE report represent the **RATE** of hospital acquired pressure ulcers at a particular facility per 1000 hospital days.   The rate is calculated using the total hospital days of care as the denominator and the number of patients who developed a Hospital Acquired Pressure Ulcer (HAPU) stage II or greater as the numerator and normalizing per 1000 hospital days.   (Patients are limited to those who have a length of stay 48 hours or longer. Hospital days are the sum of the length of stay for discharged patients from acute medical or surgical units).

Methodology: These data represent continuous monitoring of all inpatients. Skin risk assessments and ongoing reassessments are documented in electronic medical records. Data are extracted electronically and a slate of process and outcome indicators are provided for performance improvement.

Incorrect Surgery

Incorrect surgery includes wrong patient, site, side, procedure or implant.

EFFECTIVENESS

The Institute of Medicine (IOM) considers effectiveness to be one of the six domains of healthcare quality. The IOM defines effectiveness as providing services based on scientific knowledge and refraining from services not likely to benefit.

Composite Behavioral Health Screening

This measure assesses whether Veterans are appropriately screened for alcohol misuse, depression, and post traumatic stress disorder (PTSD) at the required intervals and, if positive, receive appropriate follow-up evaluations.

Composite Diabetes

This measure assesses the quality of outpatient care for Veterans age 18-75 with diabetes. The measures in the composite address: keeping blood sugar low and measuring control of blood sugar at regular intervals (HbA1 greater than 9 % or not

done); keeping blood cholesterol low and measuring it at regular intervals (LDL-C < 100); keeping blood pressure low (BP less than or equal to 140/90 mmHg); examining for diabetes-related eye damage; and examining for diabetes-related kidney damage.

Blood pressure less than 140/90 mmHg (diabetes)

This measure is the percent of Veterans age 18-75 with diabetes whose most recent blood pressure recording is less than 140/90 mmHg.

HbA1 greater than 9 or not done in past year

This measure assesses long range blood sugar control in Veterans age 18-75 with diabetes. It is the percentage of those assessed that had a HbA1c (a test for blood sugar control) of greater than 9% or did not have a HbA1c done during the past year.

LDL-C (Cholesterol) less than 100 (diabetes)

This measure assesses cholesterol (LDL-C) in Veterans age 18-75 with diabetes. It is the percentage of those assessed who have had a cholesterol test (LDL-C) with a result of less than 100 mg/dl during the measurement year.

LDL-C (Cholesterol) less than 100 (vascular dx)

This measure assesses cholesterol (LDL-C) in Veterans with a diagnosis of vascular disease, such as stroke, peripheral artery disease, or renal artery disease. It is the percentage of those assessed who have had a cholesterol test (LDL-C) with a result of less than 100 mg/dl during the measurement year.

LDL-C (cholesterol) measured (vascular dx)

This measure assesses cholesterol (LDL-C) in Veterans with a diagnosis of vascular disease, such as stroke, peripheral artery disease, or renal artery disease. It is the percentage of those assessed who have had a cholesterol test (LDL-C) performed during the measurement year.

Blood pressure less than 140/90 (HTN)

This measure assesses blood pressure control in Veterans age 18-85 with high blood pressure (HTN). It is the percentage of those assessed whose most recent blood pressure recording is less than 140/90 mmHg.

Screening for colorectal cancer

This measure assesses whether Veterans age 50-75 received appropriate screening, based the 2008 US Preventive Services Task Force (USPSTF) guidelines. It is the percentage of those assessed who has an annual test for blood in stool (feces), a sigmoidoscopy every five years, or a colonoscopy every 10 years.

Women screened for cervical cancer

This measure is the percentage of women Veterans age 21-64 who have been screened for cervical cancer in the past three years.

Women screened for breast cancer

This measure is the percentage of women Veterans age 50-69 who were screened for breast cancer through mammography in the past two years.

Pneumococcal pneumonia immunization

This measure is the percentage of Veterans age 65 or older who have received a one time pneumococcal (pneumonia) immunization.

Obese patients offered weight management

This measure is the percentage of Veterans age 18-69 who were screened for obesity in the last year and offered an appropriate weight management program.

Composite Tobacco

This measure consists of three measures that assess whether Veterans who smoke are offered assistance to help quit. It includes the percentage of Veterans who smoke that have been offered medication to help them quit, have been referred to a specialty smoking cessation program, or have been provided with anti-smoking counseling in the past year.

Composite acute myocardial infarction (AMI)

This measure consists of several process of care measures that assess the care of Veterans with a heart attack. The individual measures include the percent of heart attack patients: (1)given aspirin on arrival to the hospital; (2) given aspirin at discharge from the hospital; (3) given angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) for decreased left ventricular systolic function (drugs used to treat heart failure as failure may occur after heart

attack); (4) given smoking cessation advice/counseling; (5) given a beta blocker (drugs used routinely after heart attacks) at discharge; (6) given Fibrinolytic medication (anti-clotting drugs) within 30 minutes of arrival to open blocked vessels; and (7) given percutaneous coronary interventions (PCI) (example- coronary stent)within 90 minutes of arrival to open blocked vessels.

Composite heart failure

This measure consists of several process of care measures that assess the care of Veterans who have been in the hospital for treatment of heart failure. The individual measures include the percent of heart failure patients: (1) given discharge instructions about heart failure; (2) had a test to examine left ventricular systolic (LVS) function (heart) (Example: Cardiac Catheterization); (3) given medications that are either angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB) for decreased left ventricular systolic function (drug used to treat heart failure); and (4) given smoking cessation advice/counseling.

Composite community acquired pneumonia (CAP)

This measure consists of several process of care measures that assess the care of Veterans who have been in the hospital for the treatment of community acquired pneumonia. The individual measures include the percent of pneumonia patients: (1) assessed and given pneumococcal vaccination to prevent pneumonia in the future; (2) who received a blood culture test before given an antibiotic; (3) given smoking cessation advice/counseling; (4) given the most appropriate initial antibiotic; and (5) assessed and given influenza vaccination.

Acute Myocardial Infarction (AMI) Risk Standardized Mortality Rate (RSMR)

The AMI RSMR estimates hospital-specific, risk-standardized, all-cause 30-day mortality rates for patients hospitalized with a principal diagnosis of heart attack. All-cause mortality is defined as death from any cause within 30 days after hospital admission - regardless of whether the patient dies while still in the hospital or after discharge. The risk-standardized ("adjusted" or "risk-adjusted") hospital mortality rate can be used to compare performance across hospitals.

Risk adjustment takes into account how sick patients were when they went in for their initial hospital stay. When rates are risk-adjusted, it means that hospitals that usually take care of sicker patients won't have a worse rate just because their patients were sicker when they arrived at the hospital. When rates are risk-adjusted, it helps make comparisons fair and meaningful.

Pneumonia Risk Standardized Mortality Rate (RSMR)

The Pneumonia RSMR estimates hospital-specific, risk-standardized, all-cause 30-day mortality rates for patients hospitalized with a principal diagnosis of pneumonia. All-cause mortality is defined as death from any cause within 30 days after hospital admission - regardless of whether the patient dies while still in the hospital or after discharge. The risk-standardized ("adjusted" or "risk-adjusted") hospital mortality rate can be used to compare performance across hospitals.

Risk adjustment takes into account how sick patients were when they went in for their initial hospital stay. When rates are risk-adjusted, it means that hospitals that usually take care of sicker patients won't have a worse rate just because their patients were sicker when they arrived at the hospital. When rates are risk-adjusted, it helps make comparisons fair and meaningful.

Congestive Heart Failure (CHF) Risk Standardized Mortality Rate (RSMR)

The CHF RSMR estimates hospital-specific, risk-standardized, all-cause 30-day mortality rates for patients hospitalized with a principal diagnosis of congestive heart Failure. All-cause mortality is defined as death from any cause within 30 days after hospital admission - regardless of whether the patient dies while still in the hospital or after discharge. The risk-standardized ("adjusted" or "risk-adjusted") hospital mortality rate can be used to compare performance across hospitals.

Risk adjustment takes into account how sick patients were when they went in for their initial hospital stay. When rates are risk-adjusted, it means that hospitals that usually take care of sicker patients won't have a worse rate just because their patients were sicker when they arrived at the hospital. When rates are risk-adjusted, it helps make comparisons fair and meaningful.

EFFICIENCY

The Institute of Medicine (IOM) considers efficiency to be one of the six domains of healthcare quality. Efficiency can be defined as avoiding waste, so measures of overuse of healthcare services are a measure of efficiency.

All Cause Readmission Rate

"Readmission" is when patients who have had a recent stay in the hospital go back into a hospital again. This measure shows how often patients are readmitted within 30 days of discharge from a previous VA hospital stay. Patients may have been readmitted back to the same VA hospital or to a different VA hospital. They may have been readmitted for the same condition as their recent hospital stay, or for a different reason.

Ambulatory Care Sensitive Conditions

The ambulatory care sensitive hospitalization rate is used to compare how well primary doctors and teams prevent admission to the hospital for patients with 14 different chronic disease (for example heart failure, pneumonia and diabetes). The measure uses diagnoses assigned to the patients with the chronic disease from the prior year, to determine the likelihood that that patient will require hospitalization in the next year.

Stochastic Frontier Analysis (SFA)

The Stochastic Frontier Analysis (SFA) is a cost efficiency model that helps measure clinical and administrative costs and then balance that to health delivery costs. In this model, for each VHA Medical Center, we estimate clinical and administrative cost efficiency using SFA. In its most fundamental form we measure the input (resources) to that of output (health delivery).

Each year the VHA Cost Efficiency Model is generated for all VA Medical Centers. Each Medical Center is indexed to an idealized, or, cost efficient frontier. The results (indices) provide a numeric assessment with <u>higher values indicating cost inefficiency</u> and <u>lower values indicating higher cost efficiency</u>. The cost efficiency indices are then utilized to assess relationships to measures of quality. Maintaining or improving quality and cost efficiency is the ultimate objective of cost efficiency measurement within VHA.

Overall Efficiency

An index that combines the clinical and administrative cost efficiency indices. A value of 1 indicates most efficient and higher value indicates less efficient

Administrative Efficiency

An index, that measures the administrative cost efficiency, (e.g. building maintenance and human resources). The index is derived by using SFA that controls for patient risk, facility characteristics and other confounding factors. A value of 1 indicates most efficient and higher value indicates less efficient

Clinical Efficiency

An Index, that measures the clinical cost efficiency, (e.g. provider salary and pharmacy costs). The index is derived by using SFA that controls for patient risks, facility characteristics and other confounding factors. A value of 1 indicates most efficient and higher value indicates less efficient.

TIMELINESS

The Institute of Medicine (IOM) considers timeliness to be one of the six domains of healthcare quality. The IOM defines timely care as reducing waits and sometimes harmful delays.

The measures under Timeliness were derived from the Survey of Healthcare Experiences of Patients (SHEP). SHEP was designed and launched in 2002 in order to consolidate multiple VHA survey programs into a single program that collects data on various aspects of the patient experience, both inpatient and outpatient. In FY10 the Inpatient SHEP Survey has fully transitioned to the sampling methods and data collection procedures used by the Consumer Assessment of Healthcare Providers and Systems -Hospital (HCAHPS) survey. The HCAHPS survey was developed by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) and are widely used in public and private healthcare settings.

All results reported here are weighted to account for the volume of patients in each site, as well as for differences in response rates. However, the scores reported here are not adjusted to account for differences in those patient characteristics known to influence patient ratings, namely self-reported health status, age, and education. As a result, scores reported here must not be compared to each other or to other external data sources.

Getting Needed Care

Combines responses from questions regarding how much of a problem, if any, patients had with various aspects of getting needed care. (Outpatient only)

Getting Care Quickly

Combines responses from questions regarding how often patients received various types of care in a timely manner. (Outpatient only)

Responsiveness of Hospital Staff

Combines responses from questions regarding how responsive hospital staff were with patients. (Inpatient only)

PATIENT CENTEREDNESS

The Institute of Medicine (IOM) considers patient centered care to be one of the six domains of healthcare quality. The IOM defines patient centered as providing care that is respectful or responsive to individuals' needs and avoiding waits and potentially harmful delays. Patient centered data is generally obtained through patient surveys designed to collect information on perceptions of care.

The measures under Patient-Centeredness were derived from the Survey of Healthcare Experiences of Patients (SHEP). SHEP was designed and launched in 2002 in order to consolidate multiple VHA survey programs into a single program that collects data on various aspects of the patient experience, both inpatient and outpatient. In FY10 the Inpatient SHEP Survey has fully transitioned to the sampling methods and data collection procedures used by the Consumer Assessment of Healthcare Providers and Systems -Hospital (HCAHPS) survey. The HCAHPS survey was developed by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) and are widely used in public and private healthcare settings.

All results reported here are weighted to account for the volume of patients in each site, as well as for differences in response rates. However, the scores reported here are not adjusted to account for differences in those patient characteristics known to influence patient ratings, namely self-reported health status, age, and education. As a result, scores reported here must not be compared to each other or to other external data sources.

Overall Rating of Healthcare in the last 12 Months

This measure represents the percent reporting 9 or 10 from the survey question "Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your VA healthcare in the last 12 months?" (Outpatient only)

<u>Overall Rating of Hospital Stay</u>

This measure represents the percent reporting 9 or 10 from the survey question "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?" (Inpatient only)

EQUITY

The Institute of Medicine (IOM) considers equity to be one of the six domains of healthcare quality. Equity can be understood as reducing disparities in healthcare regardless of race, ethnicity or gender.

<u>Behavior Health Composite – Gender Difference</u>

This measure represents the absolute difference between the Behavior Health Screening Composite measure for males and females.

The Behavior Health Composite is a measure that assesses whether Veterans are appropriately screened for alcohol misuse, depression, and post traumatic stress disorder (PTSD) at the required intervals and, if positive, receive appropriate follow-up evaluations.

<u>Diabetes Composite – Gender Difference</u>

This measure represents the absolute difference between the Composite Diabetes measure for males and females.

The Diabetes Composite measure assesses the quality of outpatient care for Veterans age 18-75 with diabetes. The measures in the composite address: keeping blood sugar low and measuring control of blood sugar at regular intervals (HbA1 greater than 9 % or not done); keeping blood cholesterol low and measuring it at regular intervals (LDL-C < 100); keeping blood pressure low (BP less than or equal to 140/90 mmHg); examining for diabetes-related eye damage; and examining for diabetes-related kidney damage.

<u>Tobacco Composite – Gender Difference</u>

This measure represents the absolute difference between the Composite Tobacco measure for males and females.

The Tobacco Composite is a measure that consists of three measures that assess whether Veterans who smoke are offered assistance to help quit. It includes the percentage of Veterans who smoke that have been offered medication to help them

quit, have been referred to a specialty smoking cessation program, or have been provided with anti-smoking counseling in the past year.

Prevention Composite – Gender Difference

This measure represents the absolute difference between the Composite Prevention measure for males and females.

The Prevention Composite consists of several individual measures that assess whether applicable Veterans have received prevention services: (1) percent of Veterans age 50 – 75 who received appropriate colorectal cancer screening; (2) percent of women Veterans age 21 – 64 who were screened for cervical cancer in the past three years; (3) percent of women Veterans age 50-69 who were screened for breast cancer; (4) percent of Veterans 65 and older who have ever received a pneumococcal immunization; (5) percent of Veterans 50 – 64 and 65 and older who received an influenza vaccination; and (6) percent of Veterans age 18 – 60 who were screened for obesity and if positive offered weight management.

Ischemic Heart Composite – Gender Difference

This measure represents the absolute difference between the Composite Ischemic Heart measure for males and females.

This measure consists of three process measures: (1) percentage of Veterans with a diagnosis of vascular disease, such as stroke, peripheral artery disease, or renal artery disease who have had a cholesterol test (LDL-C) with a result of less than 100 performed during the measurement year; (2) percentage of Veterans with a diagnosis of vascular disease, such as stroke, peripheral artery disease, or renal artery disease who have had a cholesterol test (LDL-C) with a result of less than 100 performed during the measurement year; and (3) percentage of Veterans age 18-85 with high blood pressure (HTN) whose most recent blood pressure recording is less than 140/90.

Behavior Health Composite – Ethnicity Difference

This measure represents the absolute difference between the Behavior Health Screening Composite measure for whites and non-whites.

The Behavior Health Composite is a measure that assesses whether Veterans are appropriately screened for alcohol misuse, depression, and post traumatic stress disorder (PTSD) at the required intervals and, if positive, receive appropriate follow-up evaluations.

Diabetes Composite – Ethnicity Difference

This measure represents the absolute difference between the Composite Diabetes measure for whites and non-whites.

The Diabetes Composite measure assesses the quality of outpatient care for Veterans age 18-75 with diabetes. The measures in the composite address: keeping blood sugar low and measuring control of blood sugar at regular intervals (HbA1 greater than 9 % or not done); keeping blood cholesterol low and measuring it at regular intervals (LDL-C < 100); keeping blood pressure low (BP less than or equal to 140/90 mmHg); examining for diabetes-related eye damage; and examining for diabetes-related kidney damage.

Tobacco Composite – Ethnicity Difference

This measure represents the absolute difference between the Composite Tobacco measure for whites and non-whites.

The Tobacco Composite is a measure that consists of three measures that assess whether Veterans who smoke are offered assistance to help quit. It includes the percentage of Veterans who smoke that have been offered medication to help them quit, have been referred to a specialty smoking cessation program, or have been provided with anti-smoking counseling in the past year.

Prevention Composite – Ethnicity Difference

This measure represents the absolute difference between the Composite Prevention measure for whites and non-whites.

The Prevention Composite consists of several individual measures that assess whether applicable Veterans have received prevention services: (1) percent of Veterans age 50 – 75 who received appropriate colorectal cancer screening; (2) percent of women Veterans age 21 – 64 who were screened for cervical cancer in the past three years; (3) percent of women Veterans age 50-69 who were screened for breast cancer; (4) percent of Veterans 65 and older who have ever received a pneumococcal immunization; (5) percent of Veterans 50 – 64 and 65 and older who received an influenza vaccination; and (6) percent of Veterans age 18 – 60 who were screened for obesity and if positive offered weight management.

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This measure represents the absolute difference between the Composite Ischemic Heart measure for whites and non-whites.

This measure consists of three process measures: (1) percentage of Veterans with a diagnosis of vascular disease, such as stroke, peripheral artery disease, or renal artery disease who have had a cholesterol test (LDL-C) with a result of less than 100 performed during the measurement year; (2) percentage of Veterans with a diagnosis of vascular disease, such as stroke, peripheral artery disease, or renal artery disease who have had a cholesterol test (LDL-C) with a result of less than 100 performed during the measurement year; and (3) percentage of Veterans age 18-85 with high blood pressure (HTN) whose most recent blood pressure recording is less than 140/90.

Overall Rating of Hospital Stay – Gender Difference

This measure represents the absolute difference between the Overall Rating of Hospital Stay measure for males and females.

This measure represents the percent reporting 9 or 10 from the survey question "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?" (Inpatient only)

Overall Rating of Hospital Stay – Ethnicity Difference

This measure represents the absolute difference between the Overall Rating of Hospital Stay measure for whites and non-whites.

This measure represents the percent reporting 9 or 10 from the survey question "Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?" (Inpatient only)

Overall Rating of Healthcare in the last 12 Months – Gender Difference

This measure represents the absolute difference between the Overall Rating of Healthcare in the last 12 Months measure for males and females.

This Overall Rating of Healthcare in the last 12 Months measure represents the percent reporting 9 or 10 from the survey question "Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what

number would you use to rate all your VA healthcare in the last 12 months?" (Outpatient only)

<u>Overall Rating of Healthcare in the last 12 Months – Ethnicity Difference</u>

This measure represents the absolute difference between the Overall Rating of Healthcare in the last 12 Months measure for whites and non-whites.

The Overall Rating of Healthcare in the last 12 Months measure represents the percent reporting 9 or 10 from the survey question "Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your VA healthcare in the last 12 months?" (Outpatient only)